STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aston Park Health Care Center	380 Brevard Road Asheville, NC 28806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record reviews, and staff interviews, the facility failed to maintain a clean floor in of 1 of 2 walk-in coolers (walk-in cooler #2). The findings included:On 4/13/26 at 9:50 AM, an observation of the kitchen's walk-in cooler #2 was made with the Food Services Manager. The back right corner of the cooler had 3 dark spots that were sticky to the touch on the floor under a cart where tea decanters were stored. The spots were 4 to 5 inches each, sticky to the touch in the centers with dried non-sticky brown circles around the edges. Further observation of walk-in cooler #2 revealed an area in the left front corner covering an 8 x 12-inch area of the floor where a dark, thick liquid substance that was sticky to the touch had pooled to 1/4 inch depth in the corner and was partially dried at the edges. Streaks of this substance stretched 5 feet from the pooled area through the doorway with scattered spots of the sticky material visible on the kitchen floor area 6 inches in front of the cooler door. During an interview with the Food Services Manager on 4/13/26 at 10:10 AM he stated the spots in the back of the cooler were likely from tea having dripped from the decanter spouts. The Food Services Manager explained he thought the pooled area and streaks in the front of the cooler were likely juice, and the streaks may have been from the wheels of a cart and might have been there about an hour.Review of the Dietary Aide Weekly Cleaning Schedule indicated the coolers were swept and mopped on Thursdays in the evening.In an interview with the Food Services Manager on 4/15/26 at 11:39 AM he stated kitchen floor cleaning between breakfast and lunch involved the floors being spot swept and mopped in all areas, and at night when closing all floors got swept and mopped with floor cleaner/degreaser. The Food Services Manager revealed there was not a sign off sheet for but this but the Assistant Food Services Manager did rounds early in the mornings to ensure the kitchen was clean before starting for the day. The Food Services Manager stated he would have expected that staff would have cleaned spills in the walk-in cooler when observed by staff.During an interview on 4/15/26 at 11:55 AM with the Assistant Food Services Manager she stated she usually came in at 5:00 AM and one of the first things she did was make sure the kitchen was clean and that the dietary staff had done their cleaning jobs the night before. The Assistant Food Services Manager explained she had come in the morning of 4/13/26 and pulled carts out of the coolers to check dates and look at the floors and did not notice any spills on the floors. She further explained that none of the other kitchen staff had told her there had been any spills in the cooler. The Assistant Food Services Manager indicated she thought the dark sticky material on the cooler floor may have been grape or prune juice from a larger juice pitcher or something from a dessert bowl that had spilled over.In an interview on 4/16/26 at 12:26 PM with Administrator she explained the sticky material on the cooler floor was in the morning so maybe it had been something that had spilled during breakfast preparations. The Administrator stated kitchen staff did a great job with cleanliness and sanitation, and this was an anomaly.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and staff interviews, the facility failed to follow their infection control policies and procedures for hand hygiene while feeding residents when Facility Aide #1 handled food with bare hands while feeding Resident #59. In addition, Facility Aide #2 handled food with bare hands while feeding Resident #59 and did not perform hand hygiene in between feeding Resident #59 and Resident #27 after touching Resident #59's food and hands. This deficiency occurred for 2 of 12 staff members observed for infection control practices while feeding residents (Facility Aide #1 and Facility Aide #2). The findings included:Review of the facility's policy titled Standard Precautions revised 11/30/22 indicates: Hands are to be washed with soap and water when visibly soiled, after direct or indirect contact with dirt, body fluids, before eating, and after using the restroom. Hand hygiene should also occur after using gloves and between resident contacts. Review of the facility's policy titled Teammate Hygiene and Handwashing revised 7/ 9/25 indicated:Teammates should never use bare hand contact with any foods, ready to eat or otherwise. All teammates should wash their hands per hand washing policies and procedures.Teammates do not need to wear gloves when distributing food to residents at the dining tables or when assisting residents to dine, unless touching ready-to-eat food.Handwashing is required to prevent cross contamination when changing tasks or activities that contaminate the hands.a. On 04/13/26 at 12:14 PM, observation was made of Facility Aide #1 assisting Resident #59 with her meal. Facility Aide #1 cut a hamburger on a bun with a knife and fork then picked up a piece of the bun and burger with her hand without using a barrier and placed it in Resident #59's hands. Resident #59 had trouble grasping the piece of bun, so Facility Aide #1 reached with both her uncovered hands and grasped both of Resident #59's hands to reposition the food in the resident's hands. Facility Aide #1 continued to feed Resident #59 using uncovered hands to pick up pieces of hamburger. During an interview on 4/13/26 at 12:21 PM with Facility Aide #1 she explained she was taught not to touch residents' food with bare hands. Facility Aide #1 stated she should have used gloves when she had to hold Resident #59's food.b. An observation was made on 04/14/26 at 12:39 PM of Facility Aide #2 placing pieces of cut meat patty in Resident #59's hands with her left hand without using a barrier. Twice while putting the food in Resident #59's hands, Facility Aide #2 touched the resident's hands with both her bare hands. Facility Aide #2 then used her left hand to pick up a spoon to feed Resident #27 without sanitizing her hands. After spoon feeding 2 bites to Resident #27 with her left hand, she then picked up a cup with her left hand without sanitizing her hands and gave Resident #59 a drink. In an interview with Facility Aide #2 on 4/14/26 at 12:50 PM she explained she had assisted Resident #59 with eating, and the resident used her fingers to feed herself but sometimes needed help getting the food. Facility Aide #2 stated she had sanitized her own hands prior to assisting the residents with this meal. When asked what she had been taught about handling food with bare hands she stated she knew not to touch food without gloves or to use a barrier like a napkin. Facility Aide #2 further explained she had tried to put the food in Resident #59's hands with the fork first and the resident would not take it, so she just used her hands. Facility Aide #2 revealed she had been trained when feeding two residents to use a different hand for each person or just touch the end of their utensil to not spread germs and to sanitize hands in between if feeding one person at a time. Facility Aide #2 stated she was left-handed and used her left hand to feed Resident #27 after touching Resident #59's food and hands. Facility Aide #2 also stated she realized what she did was not what she had been taught in the Feeding Assistant course and did not know why she did that, just that she had been focused on Resident #27 getting the bites of food. Review of training records for Feeding Assistant training revealed the course included hand hygiene, infection prevention practices while assisting with feeding, and return demonstration of correctly feeding residents. Facility Aide #1 completed Feeding Assistant training on 1/9/26 and Facility Aide #2 completed Feeding Assistant training on 3/19/26.On 4/14/26 at 4:14 PM an interview was conducted with the Staff Development Coordinator (SDC), who taught the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Feeding Assistant course to Facility Aides, and was also the Infection Preventionist. The SDC explained the hand hygiene processes taught when staff assisted residents with meals was to wash their hands before they started and sanitize their hands between residents. The SDC then explained what staff were taught when feeding two residents at the same time. She stated they needed to be careful not to break the infection prevention barrier between the two residents by keeping each resident's food and utensils separate. The SDC stated if they had broken that barrier between the two, for example by touching a resident with their hands or used the same hand to touch anything other than the end of the utensil for both residents, that they should have sanitized their hands before continuing to feed. The SDC explained she watched the Facility Aides feed residents during the Feeding Assistant course and checks on them in the dining rooms when they are first starting on their own. The SDC indicated Facility Aide #1 and Facility Aide #2 were doing well overall but had gotten confused and made a mistake. During an interview with the Assistant Director of Nursing (ADON) on 4/14/26 at 1:00 PM with Facility Aide #2 present, she explained staff were taught not to handle food with their bare hands because it was an infection risk but to hand food to a resident with a package wrapper, napkin or fork, or to wear gloves. The ADON further explained staff were taught it was alright to feed two residents at a time when using practices to prevent cross contamination. The ADON stated practices to prevent cross contamination could include using one hand for one resident and the other hand for the other resident, or to just touch the end of the resident's utensils. The ADON revealed that if staff touched a resident with their hands or used both hands while feeding one resident, they should perform hand hygiene before continuing to feed the other resident. An interview was completed on 04/16/26 at 12:35 PM with the Director of Nursing (DON), with the Administrator and SDC present. The DON explained Resident #59 had been able to use finger foods but could be a little complicated and they were trialing different ways to make it easier for staff to assist her to feed herself and stay as independent as possible. The DON stated that staff were expected to wash their hands with soap and water before handling food and to perform hand hygiene in between residents. The Administrator stated the facility usually did a good job with hand hygiene.